MEEX, Beneficiary, & Provider Processes WorkingTogether To Meet Spenddowns

Notices

- When multiple processes are used to apply expenses to a spenddown, receiving all of the notices can leave a consumer confused.
- You need to be sensitive to consumers that may have expenses applied to their spenddown through multiple processes. This can cause a lot of confusion for them if they are not familiar with the processes and notices.
- Consumers need to be educated to keep their weekly notices to help them track their progress toward meeting the remaining spenddown.
- Also, you need to be aware and knowledgeable of what notices are being sent from the MMIS system especially if you are sending a notice from KAECSES regarding a spenddown change.

I'm confused...when do I send a notice on the KAECSES system and when will the MMIS system send the notice?

Rule of Thumb!

Anytime work is done on the KAECSES system that changes a spenddown or effects the consumer's benefits a KAECSES notice will need to be sent.

- ❖ Increasing or decreasing the countable income which effects the spenddown for the base period.
- ❖ Allowing one of the four types of medical expenses on the **MEEX** screen which effects the remaining spenddown amount for the base period.
- ❖ Shortening or lengthening the base period which would effect the spenddown amount.
- ❖ Approving HCBS payments or care home payments for both temporary and long term stays.

Anytime you are doing work in the MMIS system that changes a spenddown amount the system will automatically send a weekly notice or a spenddown summary notice to the consumer.

- ❖ Entering a beneficiary billed claim in the MMIS system.
- ❖ Voiding a beneficiary billed claim in the MMIS system.

Everybody wins when notices are clear, complete, and concise.

KAECSES Notice Tip Sheet

- ♦ Notices are printed each evening and mailed the following work day.
- ♦ The reverse side of all notices sent from KAECSES has information about fair hearings, civil rights, fraud penalties, reporting changes, and contact numbers. This information is printed in both English and Spanish on the back of each notice.
- ♦ The case location field on the **ADDR** screen determines the return address that is printed on the envelopes of notices
- ♦ In all Working Healthy cases, add the Benefits Specialist's name to the **ADAD** screen, so that they may receive copies of the notices. This is not a confidentiality issue, since they are SRS employees and have reason to know about the consumer's eligibility.

More Claims Information

Once a spenddown is met, it is recommended that you do **not** enter any further beneficiary billed claims into the system. It is a good idea to go ahead and keep these expenses in the case file, especially around mass change. If the spenddown should increase in the future, you already have verification of out-of-pocket expenses to apply to the new spenddown. If not, you could allow on future base periods if the bill meets the due and owing criteria.

Example - Medicaid only

Jackie Robinson has a spenddown of $1,700 for November to April. In November, Jackie is hospitalized. The hospital, the doctor, and the anesthesiologist all bill Medicaid for the services they provide and the spenddown is met.

Later that month, Jackie incurs a dental expense of $75 from a non-Medicaid provider. The worker receives the completed beneficiary billed form and files it for easy reference. They realize mass change is just around the corner and when Jackie's spenddown increases with the COLA they can easily apply this claim to the increased spenddown amount.

Claim Adjustments

If the last claim that was used to meet the spenddown has no potential for provider payment (beneficiary billed claims or provider billed claims in which payment is denied), previous claims will be reviewed to ensure that non-PPP claims are used prior to claims with PPP.

Example - Medicaid only

Ted Williams has a spenddown of $225 for the months of December to May. A provider billed (PB) claim from Dillon's Pharmacy is received for $200 on December 18th, the MMIS applies it to the spenddown, and assigns a PPP indicator of **Y**. The remaining spenddown is $25 in the MMIS system.

In January, the worker receives a beneficiary claim form for eye glasses Mr. Williams received from The Optical and Cryogenics Clinic in the amount of $325. The worker enters this claim on the Beneficiary Spenddown Claim window in MMIS. The spenddown is met.

The MMIS knows the last expense used to meet the spenddown has no potential for provider payment, so it reviews the previous claims. It sees that if it applies the entire eye glass expense to the spenddown, then the previous provider billed claim from Dillon's can be paid. It adjusts the claims accordingly.

If Ted was a Medicare beneficiary without Medicare Part D coverage, MMIS would apply the $200 prescription expense to the spenddown, and assign a PPP indicator of **N**. There would be no potential for Medicaid payment as Ted is entitled to prescription coverage through Part D.

Likely To Meet A Spenddown?

MS Spenddowns:

- With initial application, a worker is not able to know if a person is likely to meet their spenddown or not. A six-month base period should be determined regardless of whether there is any indication the spenddown can be met.

- At the end of a base period, the worker should inquire into the interChange MMIS system to identify if any expenses were applied to the previous six-month base.

- If there were no expenses applied to the spenddown, the worker should contact the consumer to evaluate the need for establishing another six-month base.

    - ❖ If there is no need indicated, the case may be closed for "unlikely to meet a spenddown" or for "client request."

    - ❖ If there is no need to establish another six-month base, but consumer is QMB or LMB eligible, set up case on one-month base.

    - ❖ If the consumer indicates a need for a spenddown, a new six-month base period will be established.

- If some expenses were applied to the spenddown, but not enough to satisfy the spenddown, there may be reason to believe the consumer has potential of meeting a new six-month base period because of the medical need.

    - ❖ Contact with the consumer at this point is recommended to make sure it is their desire to have an additional base period established.